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ABSTRACT

This guide provides background information to help interpret Iowa state and federal rules as they apply to occupational therapy (OT) for students with disabilities (birth to age 21) in educational settings. The first section is on personnel and provides definitions and statements of licensure for the positions of occupational therapist and occupational therapy assistant. The second section is on service delivery and provides standards and guidelines for teaming; identification (including screening, referral for OT assessment, OT assessment areas, and determining need for OT services); Individualized Family Service Plan development; Individualized Educational Program development (including the IEP team, process, and components, and determining the delivery method for OT service); determining the amount of OT service; effective therapy intervention; and OT exit criteria. The third section addresses administrative considerations such as recruitment, employment, and retention of OT personnel; orientation of new staff; workload considerations; equipment and space; documentation; supervision and evaluation; continuing education and staff development; interagency collaboration; and liability. Appendices include a sample form for recording OT entrance and exit criteria; several models of OT service delivery; a list of factors to consider when deciding on amount of OT service; and a list of terms recommended for a uniform terminology. (Contains 10 references.) (DB)

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Iowa Guidelines for Educationally Related Physical Therapy Services

EC 305284

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INTRODUCTION

In 1975, Congress enacted Public Law 94-142, The Education of All Handicapped Children Act which, in conjunction with the Iowa Special Education law, provided the foundation for education of all handicapped children, provision of services, rights to due process, and equal protection. This legislation mandated a free and appropriate public education, including support services such as occupational therapy, to assist the child with a disability to benefit from special education.

Although occupational therapists have provided services in public and private schools throughout the history of their profession, The Individuals with Disabilities Education Act (IDEA, Public Law 101-476, previously P.L. 94-142 and P.L. 99-457) and Section 504 of the Rehabilitation Act of 1973 have broadened the role of therapists and increased the demand for employment of therapists and assistants throughout the state and the nation.

The purpose of this document is to provide general background information and to help interpret state and federal rules as they apply to occupational therapy in educational settings. Therapists, parents, and administrators across the state of Iowa had input throughout the development and revision process of the initial document. This document is intended to serve as a guideline so that each area education agency (AEA) employing therapists can establish or update specific agency guidelines for providing these support services to students (birth to 21 years) in special education.

Inherent in this document are the following assumptions:

1. Individuals eligible for special education should be served in the least restrictive educational environment possible. Infants and toddlers should be served in natural environments.

2. The educational relevance of an activity is defined by the educational curriculum and educational needs of the student.

3. The educational environment is the location where a student's curriculum is being implemented. For example, the educational environment of an infant may be the home; for a school-aged student it would be the school and surrounding grounds, and for a student with prevocational or vocational goals, it may include the community.

4. Motor functioning and adaptive abilities are areas which may be assessed by various disciplines (e.g., occupational therapists, psychologists, early childhood teachers and physical education teachers). Occupational therapists assess motor functioning and adaptive abilities from their unique perspective.

5. Even though services may overlap, physical therapy and occupational therapy are separate disciplines with separate entry-level educational experiences and separate licensure laws.

6. Physical therapy and occupational therapy should both be available to students in special education as needed. Equal availability of therapies is assumed.

DEFINITION: OCCUPATIONAL THERAPIST

Iowa Department of Education Rules

The *Rules of Special Education*, Education[281]—§41.9(3)"f," Iowa Administrative Code, defines the occupational therapist (OT) as "a licensed health professional who applies principles, methods and procedures for analysis of, but not limited to, motor or sensorimotor functions to determine the educational significance of identified problem areas including fine motor manipulation, self-help, adaptive work skills, and play or leisure skills in order to provide planning, coordination, and implementation of intervention strategies and services for eligible individuals."

Special education personnel shall meet the Board of Educational Examiners requirements for the position for which they are employed. For occupational therapists working in educational environments, this involves meeting the requirement for a statement of professional recognition (SPR).

Statement of Professional Recognition

As stated in Educational Examiners[282]—Chapter 15, Requirements for Special Education Endorsements, March 31, 1996:

§282—15.3(12) *School occupational therapist.*

a. *Authorization.* The holder of this authorization can serve as a school occupational therapist to pupils with physical impairments from birth to 21 (and to a maximum allowable age in accord with Iowa Code section 281B.8).
The legalization for this support personnel is through a statement of professional recognition (SPR) and not through teacher licensure.

b. *Program requirements.*
(1) Degree or equivalent baccalaureate in occupational therapy.
(2) Hold a valid license to practice occupational therapy in Iowa as granted by the division of licensure, Iowa Department of Public Health.
Procedure for acquiring a statement of professional recognition (SPR): The special education director (or designee) of the area education agency must submit a letter to the Board of Educational Examiners, licensure bureau, requesting that the authorization be issued. Additionally, these documents must be submitted:

1. A copy of a temporary or regular license from the division of licensure, Iowa Department of Public Health.
2. An official transcript.
A temporary SPR will then be issued for one school year if the class of license from the Iowa Department of Public Health is temporary.

A regular SPR will be issued with the verification of a regular license.

Occupational Therapy Licensure

An occupational therapist is a person licensed by the Iowa Physical and Occupational Therapy Board of Examiners to practice occupational therapy [§148B.2(3), 1993 Iowa Code].

Occupational therapy means the therapeutic application of specific tasks used for the purpose of evaluation and treatment of problems interfering with the functional performance in persons impaired by physical illness or injury, emotional disorder, congenital or developmental disability or the aging process in order to achieve optimum function, for the maintenance of health and prevention of disability [§148B.2.(2), 1993 Iowa Code].

Comment

The occupational therapist is a member of a multidisciplinary, educational team whose purpose is to determine eligibility and to develop an individualized education program or an individualized family service plan for the individual requiring special education services. The therapist utilizes his/her expertise to develop and maintain the occupational performance of a student for functional independence in the least restrictive educational setting. The occupational therapist and occupational therapy assistant working in an educational environment are not responsible for the total rehabilitative or habilitative needs of each student. Other aspects of a student's adaptive functioning outside of the educational setting may be the responsibility of other professionals (e.g. hospital and/or private therapists).

DEFINITION: OCCUPATIONAL THERAPY ASSISTANT

Iowa Department of Education Rules

The *Rules of Special Education*, Education [281]-41.10(256B)"d," Iowa Administrative Code defines an occupational therapy assistant as "licensed to perform occupational therapy procedures and related tasks that have been selected and delegated by the supervising occupational therapist."

Occupational Therapy Assistant Licensure

An "occupational therapy assistant" (OTA) is defined as a person licensed to assist in the practice of occupational therapy according to §148B.2(4), 1993 Iowa Code. Supervision shall be provided according to the administrative rules, Professional Licensure [645] Chapter 201, which state:

645-201.13(272C) Supervision

201.13(1) The occupational therapy assistant and limited permit holder practice occupational therapy under the supervision of an occupational therapist licensed in the state of Iowa.

[NOTE: "limited permit holders" are OTs and OTAs who have completed the educational and experience requirements to be licensed and are waiting to take the certification examination.]

a. Supervision of the licensed occupational therapy assistant shall include a minimum of four hours per month of on-site and in-sight supervision by the occupational therapist.

b. Supervision of the limited permit holder shall include one-to-one supervision for a minimum of two hours per week by the occupational therapist.

201.13(2) Supervision of the licensed occupational therapy assistant and occupational therapy assistant limited permit holder shall include:

a. The evaluation of each patient by the supervising occupational therapist prior to treatment by the licensed occupational therapy assistant or limited permit holder. This time spent in evaluating the patient by the therapist shall not be considered time spent supervising.

b. A treatment plan written by the supervising occupational therapist outlining which elements have been delegated to the licensed occupational therapy assistant or limited permit holder.

c. Monitoring of patient progress by the supervising occupational therapist.

d. Evaluation of the treatment plan and determination of treatment termination by supervising therapist.

201.13(3) The occupational therapist holding a limited permit may perform the duties of the occupational therapist under the supervision of an Iowa licensed occupational therapist, except for providing supervision to an occupational therapy assistant.

201.13(4) The licensed occupational therapy assistant and limited permit holder must designate on a board-approved form the supervising occupational therapist and the facilities within which the occupational therapy assistant or limited permit holder works. Any change in supervision or facility should be reported to the board within seven days after the change takes place.

201.13(5) A supervision plan and documentation of supervision shall be kept by each occupational therapy assistant or limited permit holder and be available for review upon request of the board.

201.13(6) The applicant for permanent licensure who is already certified and working in the scope of occupational therapy prior to licensure shall receive the same supervision as set out in 201.13(1)"b" and 201.13(2) for occupational therapy assistants and 201.13(1)"b" and 201.13(3) for occupational therapists.

a. The applicant shall include on the application form the name of the Iowa-licensed occupational therapist who will be providing supervision until the applicant is licensed.

b. The application shall be completed within 90 days.

c. The applicant shall notify the board within seven days of any changes in supervision.

201.13(7) The occupational therapist shall ensure that the occupational therapy assistant, limited permit holder, or applicant is assigned only those duties and responsibilities for which the assistant, limited permit holder or applicant has been specifically trained and is qualified to perform.

201.13(8) When supervising unlicensed personnel not covered under 201.13(1), 201.13(2), 201.13(3) and 201.13(6) the following conditions shall be met:

a. Evaluation of patient by the occupational therapist.

b. Treatment plan determined by the occupational therapist with delegation of specific treatment responsibilities in writing.
c. The occupational therapist shall monitor patient progress, change treatment plan as indicated and determine termination of treatment.

201.13(9) Care rendered by unlicensed personnel shall not be held out as, and shall not be charged as, occupational therapy unless in-sight supervision is provided by an occupational therapist.

Comment

Whenever service is provided by an occupational therapy assistant, both the supervising occupational therapist and the OTA should be identified as service personnel in the student's individualized education program (IEP) and individualized family service plan (IFSP). The occupational therapist shall maintain written records of all therapy programs.

In an educational setting, OTAs are directly supervised by occupational therapists and provide services to individuals requiring special education services who have been identified on their IEP or IFSP as needing occupational therapy. If an OTA is supervised by someone other than an occupational therapist, the services delivered by the OTA may not be considered occupational therapy.

Within the school setting, OTAs are trained to provide occupational therapy services but are not to be considered as or hired as occupational therapists (OTs). The actual duties of the OTA shall be determined by the supervising OT based on the needs of the student population requiring the service and the appropriate service delivery model.

Other Personnel

In the educational setting, other personnel (i.e., teachers, parents, other support service personnel, motor technicians or programmers, paraprofessionals or volunteers) are called upon to implement activities which will enhance the student's educational performance. Some of these activities may be delegated by the occupational therapist. The types of activities which are delegated should not require the expertise of a therapist and should be appropriate for the educational environment. The therapist should maintain written records of delegated tasks, document training of the designated personnel, and monitor the student's performance.

The activities which are performed by personnel other than the licensed occupational therapist or occupational therapy assistant, cannot be called occupational therapy unless direct in-sight supervision is given. Professional Licensure [645] Chapter 201 201.13 (9).

Role of the Occupational Therapist in the Educational Setting

Occupational therapists are health professionals trained to identify deficit and strength areas within human occupational performance as it occurs within context. Occupational therapy assistants are also licensed to perform occupational therapy procedures and tasks that have been delegated by a supervising therapist. Interven-

tion is designed to enhance the individual's occupational performance (i.e. activities of daily living, educational or work skills, play or leisure skills) within the needs of the environment. In addition to academic preparation, emphasis on team collaboration, legislative aspects of service within the educational setting, team process of developing individualized education programs (IEPs) and individualized family service plans (IFSPs), and working with families is important knowledge for therapists choosing to work in this setting.

Occupational therapists and OTAs working in educational environments provide services that assist students in benefiting from their educational program. Some of these students do not have an identified medical diagnosis or impairment. In Iowa, a medical referral is not a necessary prerequisite for an eligible individual to receive occupational therapy services in educational settings. The student's capabilities and needs in relation to his/her present level of educational performance are the focus for identifying goals, objectives and services to promote function within the educational environment. However, pertinent medical and health information should be obtained and considered by the occupational therapy personnel and other IEP or IFSP team members.

A student may have a medical diagnosis or impairment, identified by personnel in a medical facility, which does not interfere with his/her educational performance. The medical diagnosis, as well as any information from the medical community, may be considered by the IEP or IFSP team when appropriate. However, if the team determines that implementation of the student's educational goals and objectives does not require the services of occupational therapy, then the occupational therapist providing services through an educational agency does not have an identified role in this situation. The student's family may pursue therapy services, such as private therapy, outside of the educational setting at their own expense. The team may provide information regarding outside therapy resources at the family's request.

Other students may have a medical diagnosis which significantly affects their school performance. In this case, the student may require occupational therapy services in both medical and educational settings. The role of the therapist in the educational setting would be to provide service to the student as identified on the IEP or IFSP as well as to communicate with medical personnel, including private or hospital-based therapists, involved with the student.

In the educational setting, the needs and demands placed on the student may change from year to year. Therefore, the IEP or IFSP team may decide that the role of the occupational therapist and the amount and type of service may also need to be changed. The role of the occupational therapist working in educational environments is to assist the student in benefiting from his/her educational program, not to meet the total medical needs of the student.

TEAMING

Federal and state laws identify several different kinds of teams: a multidisciplinary team, an individualized family service plan team, and an individualized education program team. The role of the occupational therapist as a member of any team is to work with other members to assist the student and his/her family to identify the student's priorities, strengths, and needs; to plan strategies and goals for educational performance; and to anticipate outcomes for the future. In addition to providing unique professional expertise, therapists can be a resource to the team by explaining aspects of a medical disability and the relationship of that disability to the student's expected educational performance, and by facilitating interagency coordination.

Both IFSP and IEP teams use consensus decision making to identify a student's goals, objectives and services. A consensus is a general agreement, built on trusting relationships, and achieved informally by seeking similarities and combinations of opinion. Decisions should be based on collected data or present the opportunity for ongoing data collection. Consensus does not necessarily infer 100% agreement, but it does mean that each team member accepts the decision.

For infants and toddlers (0 through 2 years of age) occupational therapists function as members of an early intervention evaluation and assessment team, that is multidisciplinary and typically interagency, in order to determine the need for early intervention services. The family is an integral part of this team. If a developmental delay is identified, the IFSP is formulated and includes a statement of the family's resources, priorities and concerns relating to enhancing the development of the child. Major outcomes expected to be achieved by the child and child's family are recorded, and specific early intervention services (such as occupational therapy, physical therapy, speech pathology, audiology, special instruction) are identified. In some cases it may be appropriate for outside agencies to be identified as the service provider for occupational therapy instead of, or in addition to, the education agency. An occupational therapist may be identified to serve as the service coordinator if he/she represents the profession most relevant to the child's or family's needs.

For students 3 to 21 years of age, occupational therapists may function as members of the multidisciplinary team to determine if a student is eligible for special education services. Other members of the team may include, but are not limited to: a teacher, physical therapist, speech-language pathologist, school audiologist, school psychologist, school social worker, educational consultant, nurse, and school principal. If the student is eligible for special education service, then the IEP team is identified. The IEP team may include all the previously mentioned individuals, along with the parents, and the student as appropriate. Each team is individualized according to the needs of the student. For students requiring occupational therapy, the respective therapist should be part of the IEP team. When a student is receiving occupational therapy support services only, The *Iowa Rules of Special Education* [Education[281—§41.62(1)"a," "b," "d," "e," and §41.68, Iowa Administrative Code] state that the IEP team shall include "the general education teacher" and "the special education support service specialist with knowledge in the area of need," as well as "a representative of the agency who is qualified to provide or supervise the provision of special education, and who has the authority to commit resident LEA resources," "one or both of the individual's parents," and the "individual, if appropriate."

IDENTIFICATION

Screening

Early detection may provide intervention at a critical time in the child's life when it may be most helpful. Screening offers the OT an opportunity to review existing information and begin gathering new data relative to the initial concern. The OT may perform an informal or formal screening, following building procedures, to determine if a significant discrepancy in performance exists that would warrant ongoing assessment or problem-solving activities. Occupational therapy assistants may conduct screenings under the supervision of the OT. Occupational therapists and OTAs may play a key role in district-wide and local school "child find" activities, but more typically, therapists consult and provide inservice for other school personnel who regularly screen groups of general and special education students.

Screening may include but, is not limited to, the use of any of the following methods:

1. Review of written information (i.e., school and/or medical records, teacher notes).
2. Review of previous attempts to remediate the presenting problem, including progress monitoring data.
3. Interview with teachers or parents.
4. Direct observation (i.e., checklists, a systematic comparison with peers).
5. Formal screening tools.(Denver Developmental Screening Tool)

Following screening, the screener should utilize the local education agency's (LEA's) or area education agency's (AEA's) policies to pursue additional assistance for the student.

General Education Interventions

"Each LEA, in conjunction with the AEA, shall attempt to resolve the presenting problem or behaviors of concern in the general education environment" [Education[281]—41.48(2), Iowa Administrative Code]. A typical LEA process might be the utilization of building-level teams to assist the general education teacher in identifying ways to solve a student's classroom problem. Occupational therapists are usually not members of these teams but may be contacted by another AEA building representative. It is the responsibility of the AEA occupational therapist to identify, for the building-level team, the types of concerns which might appropriately require their expertise. When the general education intervention requires the expertise of AEA staff, OTs may be involved in a problem-solving process which includes measurable outcomes, data collection and decision making, and goal-directed interventions. The systematic problem-solving process, including the use of systematic progress monitoring, is described in the *Rules of Special Education* [Education[281]—41.47(3), Iowa Administrative Code]. When infants or toddlers, not requiring or ineligible for an IFSP, have an identi-

fied concern, these interventions would be provided by the parents in the home environment with assistance from AEA early intervention staff. Each AEA determines the extent to which their occupational therapy staff participate in these general education or home-based interventions.

Identification for Special Education

Each AEA is responsible for developing an identification process which includes active parent participation. "Whenever a general education intervention is not appropriate to the needs of the individual, the multidisciplinary team may determine that a full and individual evaluation shall be conducted" [Education[281—§41.48(2), Iowa Administrative Code]. Occupational therapists, following their AEA procedures, are members of this multidisciplinary team and participate in the full and individual evaluation when their expertise is needed. Specific AEA identification procedures will affect the assessment process and decisions.

Referral for Occupational Therapy Assessment

Referrals to the OT as part of the full and individual evaluation, for individuals birth to 21 years, are made by the multidisciplinary team when the infant, toddler, preschooler, or school-age student is being considered for special education services or at any time when an educational disability is suspected. The referral process should follow AEA procedures in accordance with state and federal statutes and regulations.

The assessment should always focus on the problem(s) identified in student performance areas. To assure that all individuals needing services are assessed, and to guard against over-assessment, the educational team should keep in mind the effect of the student's problem on his/her educational program, and the ability of other professionals to perform the assessment. A referral for occupational therapy is indicated when a problem is noted in the performance areas of activities of daily living, educational and work activities, and play and leisure. Area education agency OTs should provide their educational teams with indicators for appropriate referral.

Assessment

Assessment, as defined in these Guidelines, refers to a systematic process of gathering and interpreting information when it is believed that an individual (birth-21 years) may require special education services or when an individual is already receiving special education. This information is used both to determine eligibility for special education services and to identify appropriate services. Information from the assessment is used by the evaluating therapist and the rest of the IEP or IFSP team to identify the student's present level of educational performance, goals, objectives and effective interventions.

Assessment involves obtaining and interpreting data related to the previously identified educational problem. Data may be gathered through record reviews, specific behavioral observations, interviews, the use of standardized tests, performance checklists, and other data collection procedures. It is assumed that some type of problem-solving activity has occurred prior to initiating an assessment request. It is important to include observations of performance in context and in settings in which

the behavior naturally occurs. Information gathering should be coordinated with the family and other team members as appropriate.

It should be noted that standardized tests are not always used by occupational therapists. In many instances, normative data do not exist for individuals being evaluated by therapists. The therapist is responsible and accountable for selecting appropriate assessment procedures that are designed to document developmental level, physical status, functional, and adaptive abilities as they affect educational performance. While motor functioning and adaptive behaviors are areas assessed by OTs, other disciplines may also be involved in these assessments.

Occupational Therapy Assessment Areas

The American Occupational Therapy Association (AOTA) published a paper on uniform terminology outlining performance areas, components and contexts which are addressed during assessment and intervention (AJOT, 1994). This document was used extensively in developing the following assessment considerations (see Appendix D).

Performance Areas

The areas and examples appropriate for the occupational therapists practicing within the educational setting include:

A. *Activities of Daily Living* - Self-maintenance tasks

1. Feeding and Eating - Selecting and using appropriate utensils and table ware; bringing food or drink to mouth; cleaning face and hands; sucking, masticating, swallowing; management of alternative methods of nourishment.

2. Dressing - Dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; applying and removing personal devices, prostheses, or orthoses.

3. Hygiene - Combing and brushing hair; caring for skin, ears, and eyes; brushing teeth; maintaining bathing position; transferring to and from bathing positions; clothing management during toileting; maintaining toileting position; cleaning and maintaining personal care devices.

B. *Educational and Work Activities* -

1. Utilizing Educational Materials - Meeting speed and accuracy demands of the environment.

2. Functional Communication - Using methods to interact with persons in environment includes handwriting, assistive technology and augmentative communication.

3. Mobility/Transitions - Accessing learning environment.

4. Socialization - Interacting with persons in educational environment.

C. *Play or Leisure Activities* -
1. Identifying interests, skills, opportunities;

2. Planning and participating in play, recess or leisure activities;

3. Utilizing toys, games or equipment.

Performance Components

The components are fundamental human abilities and are the elements of the performance that are assessed. Definition of the components are found in Appendix D. Examples for the occupational therapist in an educational setting may include:

1. *Motor Performance* (NOTE: A developmental motor level is used to identify a delay when determining eligibility for early intervention services).
   a *Gross motor coordination*
   b *Fine motor coordination/dexterity*
   c. *Visual-motor integration*
   d. *Oral-motor control*
   e. *Praxis*
   f. *Motor Control*
   g. *Crossing the Midline*
   h. *Laterality*
   i. *Bilateral Integration*

2. *Neuromusculoskeletal Components*
   May include any of the following:
   a. *Reflex*
   b. *Range of Motion*
   c. *Muscle Tone*
   d. *Strength*
   e. *Endurance*
   f. *Postural Control*
   g. *Postural Alignment*
   h. *Soft Tissue Integrity*

3. *Sensory Awareness and Processing* - Ability to receive input, process information and produce output, including the receipt, differentiation and interpretation of any of the following:
   a. *Tactile*
   b. *Proprioceptive*
   c. *Vestibular*
   d. *Visual*
   e. *Auditory*
   f. *Gustatory*
   g. *Olfactory*

4. *Perceptual Processing* - Organizing sensory input into meaningful patterns:
   a. *Stereognosis*
   b. *Kinesthesis*
   c. *Pain Response*
   d. *Body Scheme*

4. *Perceptual Processing* (Continued)
   e. *Right-left Discrimination*
   f. *Form Constancy*
   g. *Position in Space*
   h. *Visual-Closure*
   i. *Figure Ground*
   j. *Depth Perception*
   k. *Spatial Relations*
   l. *Topographical Orientation*

5. *Adaptive Behavior*- Ability to function, accommodate, and interact in society:
   a. *Level of Arousal*
   b. *Orientation*
   c. *Recognition*
   d. *Attention Span*
   e. *Initiation of Activity*
   f. *Termination of Activity*
   g. *Memory*
   h. *Sequencing*
   i. *Categorization*
   j. *Concept Formation*
   k. *Problem Solving*
   l. *Generalization*
   m. *Role Performance*
   n. *Social Conduct*
   o. *Interpersonal Skills*
   p. *Self-management*

Performance Contexts

Situations of factors which affect the performance are called performance contexts. These include:

1. *Temporal Aspects* - age, developmental stage, educational process, disability status.

2. *Environmental Aspects* - physical characteristics of environment, social routines and expectations, and culture.

Determining Need for Occupational Therapy Services

Following a comprehensive assessment of the individual, the therapist uses the data gathered to determine if occupational therapy services should be recommended to the IEP team for this student. The Occupational Therapy Entrance and Exit Criteria form was developed to assist the OT in identifying when to recommend these support services. Occupational therapy should be identified as a service only when the unique expertise of this profession is needed to meet identified student goals and/or objectives and when the absence of this profession would prevent a student from benefiting from his/her educational program. "Because of their training occupational and physical therapists are very good at devising ways to enhance a student's performance, but one must always consider if the expertise of the OT is necessary in order to assist the student in meeting specific educational outcomes. If the team decides that occupa-

tional therapy services are necessary, it is then up to the individual therapist to choose a frame of reference to guide his/her interventions on behalf of the student." (Hanft, 1996)

It is important to remember that although the occupational therapist may recommend services, the IEP team which developed the student goals makes the decision about the services needed to meet these goals. Use of the Occupational Therapy Entrance and Exit Criteria form assists the OT in determining if services should be recommended to the IEP team.

Entrance Criteria

To recommend occupational therapy as a service for a student, **ALL** of the following criteria should be met in at least one behavior of concern or presenting problem area.

1. The problem significantly interferes with the student's ability to participate in his/her educational program. (There is a significant discrepancy between the individual's performance and the expected performance).

2. The problem in a performance area appears to be caused by limitations in an occupational performance component(s).

3. Previous attempts to alleviate the problem have not been successful, as documented.

4. Potential for positive change in the student's problem as a result of intervention by occupational therapy or negative change without intervention appears likely. Change as a result of therapy should be in addition to changes due to the increasing age or general maturation of the student.

5. Unique expertise of OT is required to meet the student's identified needs.

Therapists should assist the team to justify the student's need for the support service of occupational therapy in the IEP report. To assist in decision making, an Occupational Therapy Entrance and Exit Criteria Form (See Appendix A) may be completed after evaluating the student and should be specific to that evaluation.

Determining Eligibility for Special Education

Following a full and individual evaluation by an early intervention team or multidisciplinary team, parents are invited to a meeting to determine the need for special education services and, for infants and toddlers, early intervention services. "Children who are handicapped in obtaining an education" are those individuals with disabilities who are unable to receive educational benefit from the general education experience without the provision of special education and related services...they are referred to as an eligible individual." Each AEA's child find policy will identify the manner and extent categorical designations are used. The *Rules of Special Education*, Education [281—§41.5, Iowa Administrative Code], handicapping conditions as categorized in the State of Iowa include: autism, behaviorally disordered, communication disability, deaf-blindness, deafness, head injury, hearing impairment, learning disability, mental disability, multicategorical, multiple disabilities, orthopedic impair-

ment, other health impairment, physical disability, severely disabled, and visual impairment including blindness. AEAs may identify students as eligible for special education without designating a specific disability category when an alternative process, typically a systematic problem-solving process, has been outlined in their AEA plan. [Education[281—§41.22(1)"d"(1), Iowa Administrative Code]. Based on the decision of the multidisciplinary team, the AEA director certifies the individual's entitlement for special education.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) DEVELOPMENT

P.L. 102-119 (Part H of IDEA, previously P.L. 99-457) defines services for infants and toddlers birth through age two, inclusive, who need early intervention because they are experiencing developmental delays or have a diagnosed physical or mental condition that has a high probability of a resulting developmental delay. In Iowa developmental delay is defined as a delay of 25% or more in one or more of the following areas: cognitive development, physical development, language and speech development, psychosocial development or self-help skills. Early intervention services are an interagency endeavor among the Departments of Public Health, Human Services, and Education. Following referral and assessment procedures and identification of appropriate services, a written individualized family service plan (IFSP) must be developed by the IFSP team, which must include the parent or guardian. The IFSP must be reviewed once a year and documented updates made at least at 6 month intervals. The IFSP must be developed within 45 days after assessment but, with parental consent, early intervention services may commence prior to the completion of the assessment. Because Iowa's special education services begin at birth for eligible individuals, infants and toddlers with an IFSP must also meet all the requirements for an IEP [Education [281]—§41.69, Iowa Administrative Code]. Title 20 USC §1477(d) requires that:

> The individualized family service plan shall be in writing and contain—
>
> (1) a statement of the infant's or toddler's present levels of physical development, cognitive development, communication development, social or emotional development, and adaptive development, based on acceptable objective criteria,
>
> (2) a statement of the family's resources, priorities, and concerns relating to enhancing the development of the family's infant or toddler with a disability,
>
> (3) a statement of the major outcomes expected to be achieved for the infant or toddler and the family, and the criteria, procedures, and timelines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary,
>
> (4) a statement of specific early intervention services necessary to meet the unique needs of the infant or toddler and the family, including the frequency, intensity, and the method of delivering services,
>
> (5) a statement of the natural environments in which early intervention services shall appropriately be provided,

(6) the projected dates for initiation of services and the anticipated duration of such services,

(7) the name of the case manager (hereafter in this subchapter referred to as the "service coordinator") from the profession most immediately relevant to the infant's or toddler's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities under this subchapter) who will be responsible for the implementation of the plan and coordination with other agencies and persons, and

(8) the steps to be taken supporting the transition of the toddler with a disability to services provided under subchapter II of this chapter to the extent such services are considered appropriate.

The Code of Federal Regulations (CFR 34 §303.340-346) provides additional clarification on the content of the IFSP, the requirements for development, review and evaluation of the plan and provisions for the transition of children age 3 years. "Eligible individuals who are two years of age and will reach the age of three during the school year, who are receiving FAPE, and do not require services from other agencies, may be served through an IEP" [Education[281]—§41.69, Iowa Administrative Code].

Individualized Family Service Plan Meetings

If an infant or toddler is determined eligible for early intervention services under Part H, an initial IFSP must be developed within a 45-day time period [CFR 34 §303.321(e)]. IFSP meetings are to be held initially and then annually and must include: the parent or parents of the child, other family members as requested by the parent (if feasible); an advocate (if requested by parent); the designated service coordinator; and persons directly involved in conducting the assessments; and, as appropriate persons who will be providing services to the child or family [CFR 34 §303.343]. The family is an important member of the team and all members are dedicated to a family-focused approach in identifying outcomes for the child or family and the development of a service plan. In Iowa, infants and toddlers with an IFSP identifying the need for education services, must also meet all of the federal and state requirements for an IEP. This is accomplished by adding student-specific goals and objectives to the IFSP.

INDIVIDUALIZED EDUCATION PROGRAM (IEP) DEVELOPMENT

For a detailed description of the IEP process, OTs should refer to the Iowa IEP Resource Manual. Therapists have a responsibility to be thoroughly familiar with the IEP process.

The IEP Team

Following the decision of the multidisciplinary team that an individual has a disability and needs special education services, an individualized education program (IEP) is developed. As stated in the *Rules of Special Education* [Education[281]—§41.62(1) "a"- "f" Iowa Administrative Code], participants in the meeting shall include:

A representative of the agency, other than the eligible individual's teacher, who is qualified to provide or supervise the provision of special education, and who has the authority to commit resident LEA resources...; the eligible individual's teacher,...for an individual who is receiving only special education support services other than speech-language services, the teacher would be the general education teacher, either the teacher or the agency representative shall be qualified in the area of the individual's education need; one or both of the individual's parents subject to rule 41.64; the individual, if appropriate; and, other individuals at the discretion of the parent or agency.

Occupational therapists are members of the IEP team when they have participated in a student's assessment or are already identified on the IEP as a support service provider. Decisions regarding an individual's IEP are made jointly by all members of the team at the IEP meeting. An IEP team meets at least annually to review and revise the IEP.

The Individualized Education Program: Process and Components

The team meets to develop an individualized education program (IEP) for the student determined to be eligible for special education services. According to the *Rules of Special Education*, [Education[281]—§41.67(1)-(8), Iowa Administrative Code]

The IEP shall include the following:

(1) Present levels of educational performance (PLEP).
(2) Annual goals, instructional objectives.
(3) Special education and participation in general education.
(4) Projected dates of services.
(5) Physical education.
(6) Criteria, evaluation and schedules.
(7) Transition planning.
(8) Projected graduation.

The team, including the OT and parents, collaborates to: 1) identify a present level of educational performance which states the student's needs; 2) determine the annual goals and at least two short-term objectives per goal directly related to these needs; 3) decide on the instructional, support, and related services needed as resources to help meet the student's goals and objectives; 4) identify the appropriate educational placement in the least restrictive environment; 5) decide the amount and duration of time from the instructional support and related services required to meet the student's needs; and 6) identify and delegate responsibilities to team members.

Although the occupational therapist may recommend services based on the use of the Entrance Criteria, the IEP team makes the final determination of services based on the need(s) of the student's identified educational program. When recommended by the team, occupational therapy services should be needed by the student in order to benefit from his/her educational program and should require the expertise of the therapist. Whenever occupational therapy services are provided by an OTA, the supervising therapist should also be identified on the IEP.

Occupational Therapy Service Only

In Iowa, an eligible individual may receive support services without the need for special education instructional services. Support services are defined as "the specially designed instruction and activities which augment, supplement or support the educational program of eligible individuals" Education[281—41.86, Iowa Administrative Code]. If an eligible individual requires only the services of an OT, then the IEP must satisfy all requirements and the "special education support service specialist with knowledge in the area of need shall have primary responsibility for recommending the need for support service, the type or model of service to be provided, and the amount of service to be provided...The special education support service provider shall attend the IEP meetings for the eligible individual being served" [Education[281]—41.68, Iowa Administrative Code]. When a student has an IEP, occupational therapy services are considered to be special education.

Determining the Delivery Method for Occupational Therapy Service

After a student's goals and objectives have been identified, the evaluating therapist along with the other IEP team members should consider the following factors: the least restrictive environment needed to accomplish the goals and objectives related to occupational therapy service; the type of skills to be learned and the methods and strategies of intervention anticipated; the level of expertise required to provide the service; and the need for and availability of others to carry out the student's program (see Appendix B). A change in the type or model of service would constitute a change in the student's IEP and would, therefore, require another IEP meeting.

The *Rules of Special Education*, Education[281]—41.86(1) Iowa Administrative Code, identify five service delivery methods common to all support services. They include:

a. Cooperative efforts of special education support personnel and the general education teacher in the general education classroom to provide specially designed instruction and related activities.
b. Cooperative efforts of special education support personnel and special education teachers.
c. Provision of specially designed instruction by a special education support provider in the general education classroom or in an environment other than the general classroom.
d. Consultation with general education teachers and special education teachers, and may include the modification of the general education environment, curriculum and instruction.
e. Provision of support services to an eligible individual through this individual's parents, teachers, or others in the environment.

Occupational therapy service delivery, as described in these Guidelines, utilize all of the above methods. In addition, current models or methods of service delivery used by occupational and physical therapists include: direct, integrative and consultative. Therapists must be aware of the unique delivery methods within their AEA. Communication with parents and other team members regarding the manner in which occupational therapy services will be delivered and the setting in which they will be

delivered is essential. The model or type of service to be provided should be documented within the IEP in a manner that is clear to the IEP team, including the parents. Hanft (1996) states that the exclusive use of one model is ineffective and violates the IDEA mandate for individualized services for students. She believes each model should be paired with some form of collaborative consultation with other team members for optimal communication and follow through.

Direct Service Model

A direct service model usually means that the therapist works with a student individually. Therapy may occur in an isolated environment due to the need for instruction free from distraction or the need for specialized equipment not found in the classroom setting. Typically, direct service is used when frequent program changes are needed and other personnel do not have the unique expertise to make these decisions. It is the therapist's professional judgment that determines when a licensed therapist, or licensed occupational therapy assistant, is the only person uniquely qualified to carry out the therapy program. The therapist, or assistant under the supervision of the therapist, is the primary provider of service and is accountable for specific IEP short-term objectives for the student.

The emphasis of direct therapy is usually on the acquisition of occupational performance skill needed for the student's environment. The student has not achieved a level of ability which would permit transfer of skills to other environments. Often, only a short interval of direct service is needed for this skill building period before the student can participate in a less restrictive model of service. Intervention sessions may include the use of therapeutic techniques and/or specialized equipment which requires the therapist's expertise and cannot safely be used by others within the student's educational environment. In the direct service model there is not an expectation that activities will be delegated to others and carried out between therapy sessions.

Integrated Service Model

Integrated therapy service is a model of service which combines direct student-therapist contact with collaborative consultation with others involved in the student's educational program. There is an emphasis placed on the need for practice of skills and problem solving in the student's daily routine. The process of goal achievement is shared between or among those involved with the student, including the therapist, therapist assistant, teacher, parents, classroom associate, and others in a collaborative manner.

Intervention includes adapting functional and meaningful activities typically occurring in the student's routine, creating opportunities for the student to practice new skills, and collaborative problem solving with others to encourage optimal functioning and independence. Only the actual time spent providing service by the therapist, or assistant under the supervision of a therapist, is considered therapy. Activities or follow-through performed by others cannot be called occupational therapy. Integrated therapy service is provided within the student's daily educational environment and should always include others involved with the student who can carry out the delegated activities.

Consultative Service Model

Consultative occupational service is a model whereby the therapist participates in collaborative consultation with the teacher, other staff, parents, and when appropriate the student regarding student-specific issues as identified in the student's IEP goals and objectives. The therapist's input is typically needed to determine appropriate expectations, environmental modifications, assistive technology, and possible learning strategies for the student. The therapist's unique expertise may also be needed for staff and parent training. However, the therapist's expertise is not required for student-specific interventions used to accomplish the IEP goal and/or objectives.

Occupational therapy appears on the IEP as a support service and is associated with a specific IEP goal and/or objective. Since the therapist is not the primary individual responsible for carrying out the interventions related to the goal and/or objective, at least one other instructional or support service provider is also identified. The time the therapist will spend in collaborative consultation appears on the IEP.

Determining the Amount of Occupational Therapy Service

As stated in the Code of Federal Regulations (34 CFR Part 300, Appendix C, Question 51):

> "The amount of services to be provided must be stated in the IEP, so that the level of the agency's commitment of resources will be clear to parents and other IEP team members. The amount of time to be committed to each of the various services to be provided must be:
>
> 1. Appropriate to that specific service, and
>
> 2. Stated in the IEP in a manner that is clear to all who are involved in both the development and implementation of the IEP."

Occupational therapy literature or research has not mandated standards that would indicate that a certain type of problem requires a certain amount of service. The amount of service depends on numerous factors including the expected or documented potential for improvement with therapeutic intervention, the existence of a critical period for skill development, the amount of training needed by the person carrying out the program, and the amount the problem interferes with the student's educational program (refer to Appendix C). For complete instructions explaining the use of this form, refer to the *Resource Manual for Physical and Occupational Therapists*. Objective progress monitoring of student performance is necessary to determine if the amount of service is appropriate to promote progress toward attainment of the student's goals and objectives. Systematic progress or mastery monitoring procedures are recommended whenever possible. Changes in the amount of occupational therapy service can only be made following a therapy reevaluation and resulting IEP meeting.

EFFECTIVE THERAPY INTERVENTION

Occupational therapy services must be provided in a manner consistent with what is documented on the student's IEP or the infant or toddler's IFSP. Occupational therapy intervention procedures should be specific to each student's individual needs.

The frame of reference or approach used should relate to the functional occupational performance areas identified on the student's IEP goals and short-term objectives or IFSP outcomes. There are many different intervention philosophies and strategies which the therapist may choose to use. It is the responsibility of the therapist to be aware of currently accepted therapy procedures and to determine the best method to translate this knowledge into practice.

If a therapist is not trained in a specific area of intervention, consultative assistance should be considered. Ongoing staff development and continuing education goals should be identified so that therapists are qualified to meet the needs of the students they are serving. Therapists should always strive to provide interventions in the natural or least restrictive environment for each individual receiving therapy. Data collection and progress monitoring protocols should be used on a frequent and consistent basis to document the effectiveness of the intervention procedures that were chosen and to make decisions regarding changes in interventions.

Transition planning is an important aspect of therapy intervention. Typical transitions occur between programs (i.e., early intervention services to preschool, elementary to middle school, secondary to graduation). It is important for the therapist to be involved at these critical transition periods as the student's needs may change, and it may be necessary to alter the model or amount of service, or perhaps discontinue services altogether. Often many students served as young children will again need therapy services as young adults transitioning to alternative living, higher education, and/or employment.

Discontinuing Occupational Therapy Services (Exit Criteria)

When a student has completed or met **ONE** of the following criteria, the occupational therapist should recommend to the IEP team that the student should be exited from therapy services. The Occupational Therapy Entrance and Exit Criteria Form found in Appendix A may be used to assist in the decision-making process and can be useful when justifying the decision to change occupational therapy service.

1. Goals or outcomes requiring the unique expertise of an OT have been met or no longer need the unique expertise of an OT and the student has no additional goals and objectives that require the services of an OT.

2. Potential for further change as a result of occupational therapy intervention appears unlikely based on previous documented intervention attempts. Occupational therapy is no longer the appropriate service to meet the student's needs as identified through the IEP goals and objectives.

3. The behavior of concern or presenting problem ceases to be educationally relevant.

4. Therapy is contraindicated due to medical, psychological or social complications.

There must be an IEP or IFSP meeting, appropriate team involvement in decision making, and parent notification to exit a student from services.

RECRUITMENT, EMPLOYMENT, AND RETENTION OF OCCUPATIONAL THERAPY PERSONNEL

Occupational therapists and occupational therapy assistants available to work in AEAs have historically been in short supply. Active recruitment can be a time consuming but necessary activity. The *Rules of Special Education* [Education[281]—§41.20(1), Iowa Administrative Code] state that: "Each AEA plan shall include a description of the procedures and activities the AEA will undertake to ensure an adequate supply of qualified personnel...including special education and related services personnel and leadership personnel. The procedures and activities shall include...a plan that:

> a. Addresses current and projected...personnel needs...
> b. Coordinates and facilitates efforts among the AEAs and LEAs, institutions of higher education, and professional associations to recruit, prepare, and retain qualified personnel, including personnel from minority backgrounds and personnel with disabilities."

One excellent opportunity to coordinate with institutions of higher education is to work collaboratively to provide fieldwork experiences for student OTs and OTAs. The OT Consultant at the Bureau of Special Education is available to assist with these efforts by supporting therapists and assistants as they function as clinical supervisors of therapy students and by supplying institutions of higher education with information about working in AEAs and providing therapy services to individuals in special education.

According to the *Rules of Special Education* [Education[281]—§41.86, Iowa Administrative Code], "Support services are the specially designed instruction and activities which augment, supplement or support the educational program of eligible individuals. These services are usually provided by the AEA but may be provided by contractual agreement, subject to the approval of the board, by another qualified agency."

The following is a list of employment alternatives some AEAs have used:

1. Direct employment by:
   a. AEAs directly hire OT or OTA, and
   b. through contract with the AEA, individual school districts hire OT or OTA either full time or part time.

2. Contract for occupational therapy services by:
   a. contracting with a public health agency,
   b. contracting with a local rehabilitation facility or hospital, and
   c. contracting with a private practice OT.

Contracted therapists should be willing to make the transition to the provision of service in an educational environment and follow the *Iowa Guidelines for Educationally Related Occupational Therapy Services*. The Iowa Department of Education (DE) OT Consultant is available to assist AEA supervisors and contracted therapists with this transition. To be educationally relevant, contracts should include time: for travel

to the educational setting, to evaluate and reevaluate as necessary, to attend IEP or IFSP meetings, to provide the model and amount of service identified on the IEP or IFSP, to monitor and document progress, and to meet with other team members, including parents, teachers, and other AEA staff. When contracts are written for only one-on-one services away from the educational setting, AEA personnel should be identified to act as a liaison to perform the other educationally relevant services needed by the student and his/her team.

Therapists have identified a variety of reasons they choose to work for an AEA. Some of these include: flexible work schedule with a school system calendar, opportunity to work in other settings in the summer, the challenge and enjoyment of working with children birth to 21 years, the autonomy of setting their own daily schedule, and continuing education opportunities.

Many factors that contribute to long term retention at an AEA also have been identified by therapists. These include: adequate orientation and initial training, opportunities for mentoring by experienced therapists, ongoing professional development, manageable caseloads, appropriate supervision, opportunities for involvement in AEA-wide program development and/or personal development, autonomy matched to skill level, and competitive salary and benefits.

ORIENTATION OF NEW STAFF

In order to provide services which are appropriate and consistent with the educational system, the contract and direct-hire occupational therapy staff must understand both the area education agency (AEA) and local education agency (LEA) systems' policies and procedures. The following areas should be included in the orientation of the new occupational therapy staff to the AEA and LEA:

1. Orient staff to the basic philosophy of occupational therapy in an educational environment.

2. Provide the OT with:
   a. information related to federal laws and regulations concerning general and special education including the Individuals with Disabilities Education Act, The Americans with Disabilities Act, The Rehabilitation Act, Section 504, and The Technology-Related Assistance for Individuals with Disabilities Act;
   b. a copy of the *Iowa Rules of Special Education;*
   c. a copy of the *Iowa Guidelines for Educationally Related Occupational Therapy Services*, (rev. 1996), the Iowa Department of Education, Bureau of Special Education *Resource Manual for Physical and Occupational Therapists*, (1990, with current updates), and other resources available through the Bureau of Special Education OT Consultant;
   d. a copy of the previous therapist's summary of information concerning the students they will be serving;
   e. a schedule of staff development at the LEA, AEA and state level; and
   f. other relevant forms, handbooks, and schedules.

3. Inform occupational therapy staff of AEA and LEA procedures for:
   a. systematic problem-solving and progress-monitoring activities for students in general and special education,

Orientation of New Staff (Continued)

b. the determination of need for special education and development of the IEP and IFSP,
c. distribution and location of reports and IEP and IFSP documentation,
d. requisitioning materials and equipment, and
e. other relevant procedures.

4. Introduce new occupational therapy staff to:
   a. special education administrative and support staff,
   b. principals of schools serving students receiving their services,
   c. general and special education teachers and classroom associates as appropriate, and
   d. other AEA staff they will be working with.

5. Provide an opportunity for the OT and OTA to observe during home visits and in special and general education classrooms and observe other AEA therapists providing services to students.

6. Orient the OT and OTA to community resources relevant to students (birth to 21 years) with disabilities.

7. Identify other therapists and/or personnel who could serve as a mentor.

WORKLOAD CONSIDERATIONS

Each AEA plan must include "a description of procedures for monitoring the caseloads of ... AEA special education personnel to ensure that the IEPs of eligible individuals are able to be fully implemented" [Education[281]—§41.22(1)"a," Iowa Administrative Code]. A number of factors enter into an individual therapist's schedule and caseload. Because of the variability of these factors, no definite caseload guidelines have been established. However, all activities expected of a therapist; including travel, office time, lunch and break times, and all of the activities identified below; should fit into a hypothetical, weekly or monthly "paper" schedule.

The following are workload factors influencing the number of individuals in special education that the OT can adequately serve on their caseload:

1. The number of OT assessments anticipated in an average month including time for information gathering; data collection; observations in educational environments; consultation with family, other AEA staff, and teachers; documentation of assessment; attendance at meetings to determine eligibility for special education and IFSP or IEP meetings.

2. The total amount of occupational therapy service provided as identified on students' IEPs and IFSPs.

3. Supervision and training of occupational therapy assistants.

4. The amount of travel time in a typical week or month. Itinerant therapists, serving schools that are widely separated geographically, not only spend time traveling but also organizing when they arrive.

5. The amount of LEA and AEA staff and parent collaborative consultation and training that is not identified on a specific student's IFSP or IEP.

6. The amount of time spent in general education systematic problem-solving and progress monitoring activities.

7. Training of students from occupational therapy, early childhood, or special education institutions of higher education programs.

8. Other responsibilities including:
   a. participation in staff development,
   b. administrative duties, and
   c. team and committee meetings.

9. Availability of secretarial and other support assistance.

10. The experience and training of the OT.

EQUIPMENT AND SPACE

Funds should be available to the OT for specialized equipment and materials which are required to perform assessments and trial intervention sessions. Therapists and their assistants should be consulted for input on the type of equipment to be ordered. Needed equipment may include the following:

1. Positioning materials such as wedges, bolsters, feeder seats, adapted tables or chairs.

2. Therapeutic equipment such as scooter toys, microswitches, keyboard modifications, specialized writing devices.

3. Self-care devices such as special spoons or adaptive cups and bottles.

4. Developmentally and age-appropriate learning materials.

5. Assessment tools and standardized tests.

6. Expendable materials such as test protocols; and adaptive equipment such as Velcro, dycem, foam, or strapping.

7. Office equipment such as files, desks, and resource books.

Assistive technology devices which are considered to be student specific, necessary to support the student's educational program and appearing on the IEP should be procured through the LEA. The student's family and/or residential facility typically provides equipment that is not necessary for educational programming. Various resources exist regarding the identification, procurement and funding of assistive technology including Office of Civil Rights (OCR) statements and Office of Special Education Programs (OSEP) letters; *Assistive Technology: AEA Model Policies and Procedures*, 1992; *Iowa Programs Providing and Financing Children's Care and Services*,1994; and the Iowa Program for Assistive Technology (IPAT). OTs should be knowledgeable of

community funding resources and assist the family in obtaining equipment as requested. Most AEAs have an assistive technology team and a funding specialist as resources.

The therapist and/or assistant may require access to woodworking or maintenance shops in order to construct and adapt equipment needed for student functioning within the educational environment. Equipment which has been created and/or recommended by the physical or occupational therapist for educational use with specific students should include documented guidelines for how the equipment is to be used, what type of supervision is required for its use, and documentation of "informed consent" which states the limitations of the equipment's use and liability. The therapist may be held liable if an injury would result from equipment fabricated or recommended by the therapist.

DOCUMENTATION

Documentation is essential for good communication and accountability of the OT's and OTA's actions. Part of the initial assessment process and ongoing reassessment includes documentation of the student's current functioning so that future changes in performance can be measured. The IFSP and IEP should be used to document the model of service, the amount of therapy service, and modifications needed in general education. Programming strategies may also be included in the IEP. Ongoing monitoring of progress toward goal and objective achievement should be documented according to AEA and LEA procedures. Prior to the annual review of the student's program, the therapist should reassess the student's present level of performance. At the IEP meeting the OT collaborates with the IEP team to 1) identify present level of educational performance, goals, and objectives for the student, 2) reassess the appropriateness of occupational therapy as a resource to meet the student's identified goals and objectives, and 3) justify any changes in the type and amount of therapy service.

Intervention/treatment plans, progress notes and attendance logs should also be included in the OT's or OTA's documentation procedures. The frequency of progress notes should be established by each area education agency. Therapists should be accountable for intervention time as defined in the IEP and for information regarding the student's progress. Information should be collected as requested by the AEA occupational therapy supervisor so that annual service reports can be submitted as needed.

SUPERVISION AND EVALUATION

Occupational therapy supervisors have the responsibility for the appropriate delivery of educationally related occupational therapy services. They should monitor services and conduct formative and informative evaluations to determine need for changes in service delivery procedures, organizational structure, staffing patterns and personnel needs, management of caseloads, budgeting, and procedures for management of records.

Occupational therapists should systematically review their performance. This can include both self-evaluation and peer review. This review should include: 1) the student-related outcomes and quality of their services, 2) their relationships both within and outside of their disciplines as they affect their performance, and 3) the appropriateness and quality of their management and administrative functions.

Therapists must take an active role in reviewing, evaluating, and updating their disciplines' and agencies' policies and procedures as they relate to the practice of occupational therapy in the educational system. Occupational therapists should be aware of state and national trends which might affect delivery of therapy services to students in special education. When requested, on-site visitations by the Department of Education, Bureau of Special Education OT Consultant can provide assistance to AEA supervisors, administrators, and therapists for program evaluation and development.

Occupational therapists train and supervise many different personnel as they implement student-specific programs in the educational environment. They also have the legal responsibility for supervising OTAs as they carry out therapy services. The OT is directly responsible for selecting which tasks are to be delegated to other personnel. Therapists must maintain written records of tasks delegated, and specific training and supervision of other personnel. The specific activities that are delegated depend upon the therapist's professional judgment; upon the nature of the student's problems; upon the particular interventions to be delegated; and upon the expertise, skill, training, and knowledge of those carrying out the activities.

CONTINUING EDUCATION AND STAFF DEVELOPMENT

Occupational licensure laws in Iowa mandate appropriate continuing education. Occupational therapists and OTAs are responsible for meeting these requirements. They should work with their respective agencies to identify and meet their individual continuing education needs. Inservice training should be an integral part of professional staff development. The Department of Education's consultants are available for on-site technical assistance and staff training. Area education agency occupational therapy staff are encouraged to attend statewide staff development sessions offered through the Department of Education.

INTERAGENCY COLLABORATION

Occupational therapists are health professionals, and thus must maintain a close relationship with physicians and other health and human service professionals. The IFSP process mandates this collaboration, but collaboration also needs to occur for all students when appropriate. For example, when a student's medical diagnosis has implications for educational programming, an OT should obtain necessary medical information before proceeding with an assessment or intervention. Appropriately documented written and verbal communication should take place between the therapist and other agencies.

LIABILITY

Many occupational therapists carry malpractice insurance. The method of employment (direct-hire or contractual) determines the type of malpractice coverage that may be needed by the therapist. The level and scope of authority within either employment arrangement should be understood and documented by employer and employee. Therapists are personally liable for activities outside of their designated scope of authority.

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APPENDIX A

Occupational Therapy Entrance and Exit Criteria Form

	PERFORMANCE AREAS											
	Activities of Daily Living				Educational & Work Activities					Play or Leisure Activities		
Student's Name: _____ **Birth Date:** _____ **Therapist:** _____ **Entrance Date:** _____ **Review Date:** _____	Feeding and eating	Dressing	Hygiene	Other:	Utilizing educational materials	Functional communication	Mobility/Transitions	Socialization	Other:	Planning and participating in activities:	Utilizing toys, games or equipment	Other:
ENTRANCE CRITERIA: (See directions on back)												
1. Problem significantly interferes with student's ability to participate in his/her educational program.												
2. Problem appears to be caused by limitations in occupational performance component(s).												
3. Previous attempts to alleviate the problem have not been successful, as documented.												
4. Potential for change in student's problem through intervention appears likely (change unrelated to maturity).												
5. Unique expertise of therapist is required to meet student's identified needs.												
Note: Star areas which have met ALL five criteria. These indicate areas which qualify for intervention.												
EXIT CRITERIA: (See Directions on back)												
1. Goals or outcomes requiring occupational therapy have been met and no additional ones are appropriate.												
2. Potential for further change as a result of occupational therapy service appears unlikely.												
3. Problem ceases to be educationally relevant.												
4. Therapy is contraindicated due to medical, psychological or social complications.												
NOTE: Mark areas which meet at least ONE of the above exit criteria. These areas no longer qualify for occupational therapy services. If new problems are identified, update areas which may qualify for intervention.												

This form provides a systematic decision-making process to assist in deciding when occupational therapy services should be recommended to help a student meet his/her IEP goals and objectives (including IFSP outcomes). Entrance criteria should be used following the therapist's evaluation, to identify the student's educational problem area(s). Exit criteria should be used following student reassessment.
REFERENCE: Rows: horizontal Columns: vertical

APPENDIX A

USE OF ENTRANCE AND EXIT CRITERIA FORM

Rationale

This form for occupational therapy entrance and exit criteria is to be used to assist in the decision-making process of determining the appropriateness of identifying occupational therapy as a support service on a student's IEP. It does not delineate the type or amount of service which would be most appropriate to help the individual benefit from his/her educational program. Those are separate decisions that are made after it is decided that occupational therapy is an indicated service to meet a specific student's goals and objectives. Keep in mind that traditional therapy concerns such as range of motion, strengthening, improving balance, and prevention of contractures may be a means for accomplishing a student's educational goals but are not the goal themselves. Parts of this form will rely on professional judgment following a complete occupational therapy assessment.

Directions:

This is a systematic decision-making process to assist in deciding when OT services are an appropriate resource to help a student meet his/her IEP goals and objectives.

Entrance:

Following the occupational therapist's assessment, the student's educational problem(s) should be identified in the performance areas listed. Indicate educational relevance for every performance area by marking the first row with a "yes" for relevance, "no" if not relevant, or "NA" when it is not an area of concern. Then, for performance areas marked with a "yes," check those additional entrance criteria statements down the column. Star the final row under the Entrance Criteria section if **all** criteria have been met to indicate performance areas to be targeted for intervention. If all five entrance criteria have not been checked, then that area would not qualify for occupational therapy intervention.

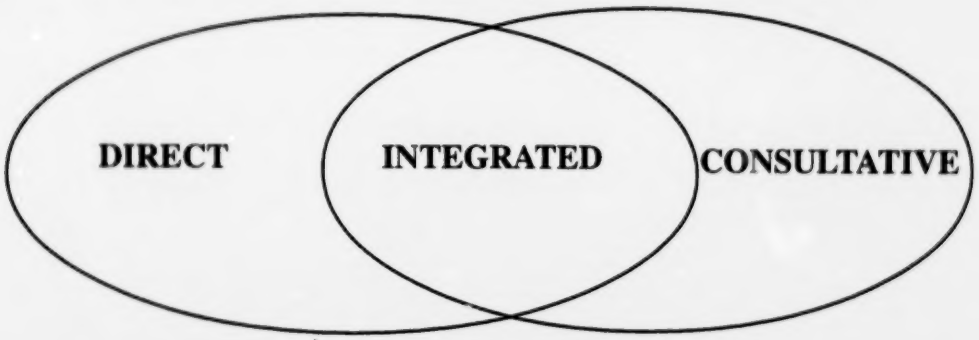
Exit:

Following student reassessment, check any exit criteria items that apply to previously identified performance areas. Mark a zero (0) in the last column under the Exit Criteria heading when one or more of the exit criteria have been met to indicate that the performance area is no longer targeted for intervention. If exit criteria are not met, leave the final column blank. If new performance areas are identified during this process, complete a new criteria form updating the performance areas.

APPENDIX B

Models of Occupational Therapy Service Delivery

	DIRECT	INTEGRATED	CONSULTATIVE
THERAPIST'S PRIMARY CONTACT	• student	• student, teacher, parent, associate	• teacher, parent, associate, student
ENVIRONMENT FOR SERVICE DELIVERY	• distraction free environment (may need to be separate from learning environment) • specialized equipment needed	• learning environment with support of others within that setting • may include a separate environment at times	• learning environment with support of others within that setting
METHODS OF INTERVENTION	• specific therapeutic techniques which cannot be safely delegated • emphasis on acquisition of new skills	• educationally related functional activities • emphasis on practice of newly acquired motor skills within the daily routine	• educationally related activities • assistive technology • adaptive materials • emphasis on accommodations to learning environment
IMPLEMENTER OF ACTIVITIES	• OT, OTA	• OT, OTA • teacher, parent, associate, other school personnel	• teacher, parent, associate, other school personnel



APPENDIX C

Factors to Consider When Deciding on Amount of Occupational Therapy Service*

Factors	1	2	3	4
Potential to benefit with therapeutic intervention	Student demonstrates minimal potential for change	Student appears to have potential for change but at a slower rate	Student appears to have a significant potential for change	Student appears to have a high potential to improve skills
Critical period of skill acquisition or regression related to development or disability	Not a critical period	Minimally critical period	Critical period	Extremely critical period
Amount of program that can be performed by others in addition to therapist intervention	Program can be carried out safely by others with periodic intervention by therapist	Many activities from the program can be safely performed by others in addition to intervention by therapist	Some activities from the program can be safely performed by others in addition to intervention by therapist	A few activities can be safely performed by others but most of the program requires the expertise of the therapist
Amount of training provided by therapist to others carrying out the program	Teacher, staff and/or parents highly trained to meet student's needs. No additional training needed	Teacher, staff and/or parents trained but some follow-up needed	Teacher, staff and/or parents could be trained to carry out some activities	Teacher, staff and/or parents could carry out some activities with extensive training
Amount problem interferes with educational setting	Environment is accommodating and difficulties are minimal	Environment is accommodating and difficulties are moderately interfering	Environment is accommodating but difficulties are significant	Environment is not accommodating; or environment is accommodating but problems are severe

*For complete instructions for utilization of this form, refer to the *Resource Manual for Physical and Occupational Therapists*, 1990 and revisions.

APPENDIX D

UNIFORM TERMINOLOGY

I. Performance Areas:

The areas and examples appropriate for the occupational therapists practicing within the educational setting include:

A. *Activities of Daily Living* - Self-maintenance tasks
   1. Feeding and Eating - Selecting and using appropriate utensils and table ware; bringing food or drink to mouth; cleaning face and hands; sucking, masticating, swallowing; management of alternative methods of nourishment.

   2. Dressing - Dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; applying and removing personal devices, prostheses, or orthoses.

   3. Hygiene - Combing and brushing hair; caring for skin, ears, and eyes; brushing teeth; maintaining bathing position; transferring to and from bathing positions; clothing management during toileting; maintaining toileting position; cleaning and maintaining personal care devices.

B. *Educational and Work Activities* -
   1. Utilizing educational materials - Meets speed and accuracy demands of the environment.
   2. Functional Communication - Uses methods to interact with persons in environment, includes handwriting, assistive technology and augmentative communication.
   3. Mobility/Transitions - Access to learning environment.
   4. Socialization - Interaction with persons in educational environment.

C. *Play or Leisure Activities* -
   1. Identifying interest, skills, opportunities.
   2. Planning and participating in play or leisure activities.
   3. Accessing toys, games or equipment.

II. Performance Components

The components are fundamental human abilities and are the elements of the performance that are assessed. Examples for the occupational therapist in educational setting may include:

1. *Motor Performance* (NOTE: A developmental motor level is used to identify a delay when determining eligibility for early intervention services).

   a. *Gross motor coordination* - Using large muscle groups for controlled, goal-directed movements

   b. *Fine motor coordination/dexterity* - Using small muscle groups for controlled movements, particularly in object manipulation

   c. *Visual-motor integration* - Coordinating the interaction of information from the eyes with body movement during activity

II. Performance Components (Continued)

d. *Oral-motor control* - Coordinating oropharyngeal musculature for controlled movements

e. *Praxis* - Conceiving and planning a new motor act in response to an environmental demand

f. *Motor Control* - Using the body in functional and versatile movement patterns

g. *Crossing the Midline* - Moving limbs and eyes across the midsagittal plane of the body

h. *Laterality* - Using a perferred unilateral body part for activities requiring a high level of skill

i. *Bilateral Integration* - Coordinating both body sides during activity

2. *Neuromusculoskeletal Components*
May include any of the following:

a. *Reflex* - Eliciting an involuntary muscle response by sensory input

b. *Range of Motion* - Moving body parts through an arc

c. *Muscle Tone* - Demonstrating a degree of tension or resistance in a muscle at rest and in response to stretch

d. *Strength* - Demonstrating a degree of muscle power when movement is resisted

e. *Endurance* - Sustaining cardiac, pulmonary, and musculoskeletal exertion over time

f. *Postural Control* - Using righting and equilibrium adjustments to maintain balance during functional movements

g. *Postural Alignment* - Maintaining biomechanical integrity among body parts

h. *Soft Tissue Integrity*-Maintaining anatomical and physiological condition of interstitial tissue and skin

3. *Sensory Awareness and Processing* - Ability to receive input, process information and produce output, including the receipt, differentiation and interpretation of any of the following:

a. *Tactile* - Interpreting light touch, pressure, temperature, pain and vibration through skin contact/receptors

b. *Proprioceptive* - Interpreting stimuli originating in muscles, joints, and other internal tissues that give information about the position of one body part in relation to another

II. Performance Components (Continued)

c. *Vestibular* - Interpreting stimuli from the inner ear receptors regarding head position and movement

d. *Visual* - Interpreting stimuli through the eyes, including peripheral vision and acuity, and awareness of color and pattern

e. *Auditory* - Interpreting and localizing sounds, and discriminating background sounds

f. *Gustatory* - Interpreting tastes

g. *Olfactory* - Interpreting odors

4. *Perceptual Processing* - Organizing sensory input into meaningful patterns
   a. *Stereognosis* - Identifying objects through proprioception, cognition, and the sense of touch

   b. *Kinesthesia* - Identifying the excursion and direction of joint movement

   c. *Pain Response* - Interpreting noxious stimuli

   d. *Body Scheme* - Acquiring an internal awareness of the body and the relationship of body parts to each other

   e. *Right-left Discrimination* - Differentiating one side from the other

   f. *Form Constancy* - Recognizing forms and objects as the same in various environments, positions, and sizes

   g. *Position in Space* - Determining the spatial relationship of figures and objects to self or other forms and objects

   h. *Visual-Closure* - Identifying forms or objects from incomplete presentations

   i. *Figure Ground* - Differentiating between foreground and background forms and objects

   j. *Depth Perception* - Determining the relative distance between objects, figures, or landmarks and the observer, and changes inplanes of surfaces

   k. *Spatial Relations* - Determining the position of objects relative to each other

   l. *Topographical Orientation* - Determining the location of objects and setting and the route to the location

5. *Adaptive Behavior* - Ability to function, accommodate, and interact in society
   a. *Level of Arousal* - Demonstrating alertness and responsiveness to environmental stimuli

II. Performance Components (Continued)

b. *Orientation* - Identifying person, place, time and situation

c. *Recognition* - Identifying familiar faces, objects, materials

d. *Attention Span* - Focusing on a task over time

e. *Initiation of Activity* - Starting a physical or mental activity

f. *Termination of Activity* - Stopping an activity at an appropriate time

g. *Memory* - Recalling information after brief or long periods of time

h. *Sequencing* - Placing information, concepts, and actions in order

i. *Categorization* - Identifying similarities of and differences among pieces of environmental information

j. *Concept Formation* - Organizing a variety of information to form thoughts and ideas

k. *Problem Solving* - Recognizing a problem, defining a problem, identifying alternative plans, selecting a plan, organizing steps in a plan implementing a plan, and evaluating the outcome

l. *Generalization* - Applying previously learned concepts and behaviors to a variety of new situations

m. *Role Performance* - Identifying, maintaining and balancing functions one assumes or requires in society

n. *Social Conduct* - Interacting by using manners, personal space, eye contact, gestures, active listening, and self-expression appropriate to one's environment

o. *Interpersonal Skills* - Using verbal and non-verbal communications to interact in a variety of settings

p. *Self-management* - Including coping skills, time management and self-control

III. Performance Contexts

Situations of factors which affect the performance are called performance contexts. These include:

1. *Temporal Aspects* - age, developmental stage, educational process, disability status.

2. *Environmental Aspects* - physical characteristics of environment, social routines and expectations, and culture.